INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE J. HEALTH INFORMATION TECHNOLOGY

CHAPTER 1660. ELECTRONIC DATA EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1660.001. FINDINGS AND PURPOSE. (a) The legislature finds that patients deserve accurate, instantaneous information about coverage and financial responsibility to make well-informed decisions about their treatment and spending.

(b) The legislature finds that the ability of health benefit plan issuers and administrators to exchange eligibility and benefit information with physicians, health care providers, hospitals, and patients will ensure a more efficient and effective health care delivery system.

(c) The legislature finds that electronic access to eligibility information will reduce the amount of time and resources spent on administrative functions, prevent abuse and fraud, streamline and simplify processing of insurance claims, and increase transparency in premium cost and health care cost.

(d) The legislature finds that patients often request information about their health care coverage from their health care providers and that health care providers therefore need access to real-time information about their patients' eligibility to receive health care under the health benefit plan, coverage of health care under the health benefit plan, and the benefits associated with the health benefit plan.

(e) The legislature finds that adoption of technology by insurers, health maintenance organizations, and health care providers to facilitate use of electronic data exchange standards currently available will make coverage and health care electronic transactions more predictable, reliable, and consistent.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Sec. 1660.002. DEFINITIONS. In this chapter:

(1) "Administrator" has the meaning assigned by Section 4151.001.

(2) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec. 2.008(7), eff. September 1, 2011.

(3) "Enrollee" means an individual who is insured by or enrolled in a health benefit plan.

(4) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits.

(5) "Transaction standards" means the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) transaction standards of the Centers for Medicare and Medicaid Services under 45 C.F.R. Part 162.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.008(7), eff. September 1, 2011.

Sec. 1660.003. APPLICABILITY. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium insurance company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 533, Government Code;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the state child health plan or any similar plan operated under Chapter 62 or 63, Health and Safety Code; or

(4) a health benefit plan offered by an insurer or health maintenance organization that provides coverage only for dental services.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Sec. 1660.004. GENERAL RULEMAKING. The commissioner may adopt rules as necessary to implement this chapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.003, eff. September 1, 2011.

SUBCHAPTER C. IDENTIFICATION CARD PILOT PROGRAM

Sec. 1660.101. PILOT PROGRAM. (a) The commissioner shall designate a county or counties for initial participation in an identification card pilot program to begin not later than May 1, 2008.

(b) The commissioner shall require the issuer of a health benefit plan that is offered in the county or counties selected for initial participation in the identification card pilot program to issue identification cards that comply with commissioner rules to each enrollee of the plan.

(c) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1147, Sec.

2.008(9), eff. September 1, 2011.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.008(9), eff. September 1, 2011.

Sec. 1660.102. PILOT PROGRAM RULES. (a) The commissioner shall adopt rules as necessary to implement the identification card pilot program, including the coordination of a testing phase and incorporation of changes identified in the testing phase.

(b) The commissioner may consider recommendations or any other information provided in response to a department-issued request for information relating to electronic data exchange, including identification card programs, before adopting rules regarding:

(1) information to be included on the identification cards;

(2) technology to be used to implement the identification card pilot program; and

(3) confidentiality and accuracy of the information required to be included on the identification cards.

(c) The commissioner shall consider the requirements of any federal program requiring health benefit plan issuers and administrators to provide point-of-service access to physicians and other health care providers regarding eligibility information before adopting rules to implement this section.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.004, eff. September 1, 2011.

Sec. 1660.103. REQUESTS FOR INFORMATION. The commissioner may issue requests for information as needed to implement the identification card pilot program under this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1,

eff. May 25, 2007.

Sec. 1660.104. HEALTH BENEFIT PLAN ISSUER COMPLIANCE. (a) Each issuer of a health benefit plan that offers a health benefit plan in a county or counties designated by the commissioner under Section 1660.101 for initial participation in the identification card pilot program shall comply with this subchapter and rules adopted under this subchapter.

(b) To ensure timely compliance with the requirements of this subchapter, the commissioner may require the issuer of a health benefit plan to submit its procedures for implementation of the requirements to the department in the form prescribed by the commissioner.

Added by Acts 2007, 80th Leg., R.S., Ch. 209 (H.B. 522), Sec. 1, eff. May 25, 2007.